DRCTC

DIAGNOSTIC RADIOLOGY CENTEROF THE TREASURE COAST, INC.

MAGNETIC RESONANCE (MR) PROCEDURE
PATIENT SCREENING FORM

Date: ____ /____ /_____ Account #____________

Name: ____ Age ____ Height______ Weight: _________

D.O.B.: _____/_____/_____ M: ____ F: ____ Body part to be imaged today: ________________________

The MR system has a very strong magnet field that may be hazardous to individuals entering the MR environment or MR system room if they have certain metallic, electronic, magnetic or mechanical implants, devices or objects. Therefore, all individuals are required to fill out this form BEFORE entering the MR environment or MR system room.
BE ADVISED, THE MR SYSTEM MAGNET IS ALWAYS ON.

1. Do you have a cardiac pacemaker? Y ___N ___

2. Do you have any metal in your body? Y ___N ___

3. Do you have an electronic implant or device? Y ___N ___

4. Do you have a history of cancer? Y ___N ___
If yes, please describe: ______________________________________

5. Have you had an injury to the eye involving a metallic object or fragment? Y ___N ___
If yes, please describe: ______________________________________

6. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a medium or dye used for an MRI, CT, or X-ray exam? Y ___N ___

7. Do you have anemia or any disease that affect your blood, a history of renal (kidney) disease, or seizures? Y ___N ___
If yes, please describe: ______________________________________

FOR FEMALE PATIENTS

8. Are you pregnant or experiencing a late menstrual period? Y ___N ___
9. Are you currently breastfeeding? Y ___N ___

10. What health concerns/problems brought you to this office today (please describe)? ________________________
____

11. Do you have any secondary or other complaints?____
____

12. When did you first experience this problem or these problems? ______________________________________
____

13. Describe how they began or occurred: ____

14. Does your current pain remain localized or does it radiate (travel to other locations)? _____________
____

15. What tests have you had to evaluate your current complaints? (Mark all that apply):

☐ X-Rays ☐ Myelogram ☐ MRI ☐ CAT Scan
☐ Bone Scan ☐ Tomogram ☐ Other _______________________
☐ **I have had no diagnostic tests as those listed above to evaluate my current episode of complaint.**

16. Where were the above tests performed and When? ______________________________________
____

17. List any surgeries you have had (include type of surgery, date and physician or facility): ___________
____
____

18. Have you been involved in an auto accident?
☐ Past year ☐ Past 5 yrs ☐ Over 5 yrs ago ☐ Never
Describe: ____

19. Have you had any other personal injury to area of complaint?
☐ Past year ☐ Past 5 yrs ☐ Over 5 yrs ago ☐ Never
Describe:____

Please indicate if you have any of the following:

Y	N		Y	N	
__	__	Aneurysm Clip(s)	__	__	Vascular Access Port and/or Catheter
__	__	Cardiac Pacemaker	__	__	Radiation Seeds or Implants
__	__	Tattoo or Permanent Makeup	__	__	Any Metallic Fragment or Foreign Body
__	__	Electronic Implant or Device	__	__	Wire Mesh Implant
__	__	Neurostimulation System	__	__	Breathing Problem or Motion Disorder
__	__	Spinal Cord Stimulator	__	__	Joint Replacement (Hip, Knee, etc.)
__	__	Tissue Expander (e.g. Breast)	__	__	Surgical Staples, Clips or Metallic Sutures
__	__	(IUD), Diaphragm, or Pessary	__	__	Dentures or Partial Plates
__	__	Internal Electrodes or Wires	__	__	Bone Growth / Bone Fusion Stimulator
__	__	Body Piercing Jewelry	__	__	Medication Patch (Nicotine, Nitroglycerine)
__	__	Other Implant	__	__	Insulin or Other Infusion Pump
__	__	Implanted Drug Infusion Device	__	__	Any Type of Prosthesis (eye, penile, etc.)
__	__	Heart Valve Prosthesis	__	__	Magnetically Activated Implant or Device
__	__	Artificial or Prosthetic Limb	__	__	Metallic Stent, Filter or Coil
__	__	Shunt (Spinal or Intraventricular)	__	__	Implanted Cardioverter Defibrillator (lCD)
__	__	Eyelid Spring or Wire	__	__	Swan-Ganz or Thermo dilution Catheter
__	__	Claustrophobia	__	__	Bone/Joint Pin, Screw, Nail, Wire, Plate, etc.
__	__	Hearing Aid	__	__	Cochlear, Otologic, or Other Ear Implant

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Signature:____ Date: _____/____/______

Information Concerning Gadolinium Contrast Material

As part of your examination, the radiologist may deem it advisable to give you an IV. Injection of a contrast agent containing gadolinium. This injection may help the physician more accurately diagnose your condition. Although gadolinium contrast agents have been safely used in millions of cases, minor reactions (principally headache or nausea) occur in about 2% of patients, whereas serious or life threatening reactions have been reported in about I in 400,000 patients.

Have you ever had a previous allergic reaction to gadolinium contrast material? Y____N____
Do you have a history of asthma or emphysema? Y____N____

Signature:____ Date: ______/______/________

CONTRAST TYPE: ___________________________ AMOUNT: _______________CC'S

IV SITE: ___________________________________ NEEDLE GAUGE USED __________